

Working as a hospital doctor can be bad for your health with negative consequences for patients:

Burnout, wellbeing and how this is associated with
defensive medical practice in the UK.

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King's Fund Annual Conference

28th November 2019

‘Largest maternity scandal in NHS history’: Dozens of mothers and babies died on wards of hospital trust, leaked report reveals

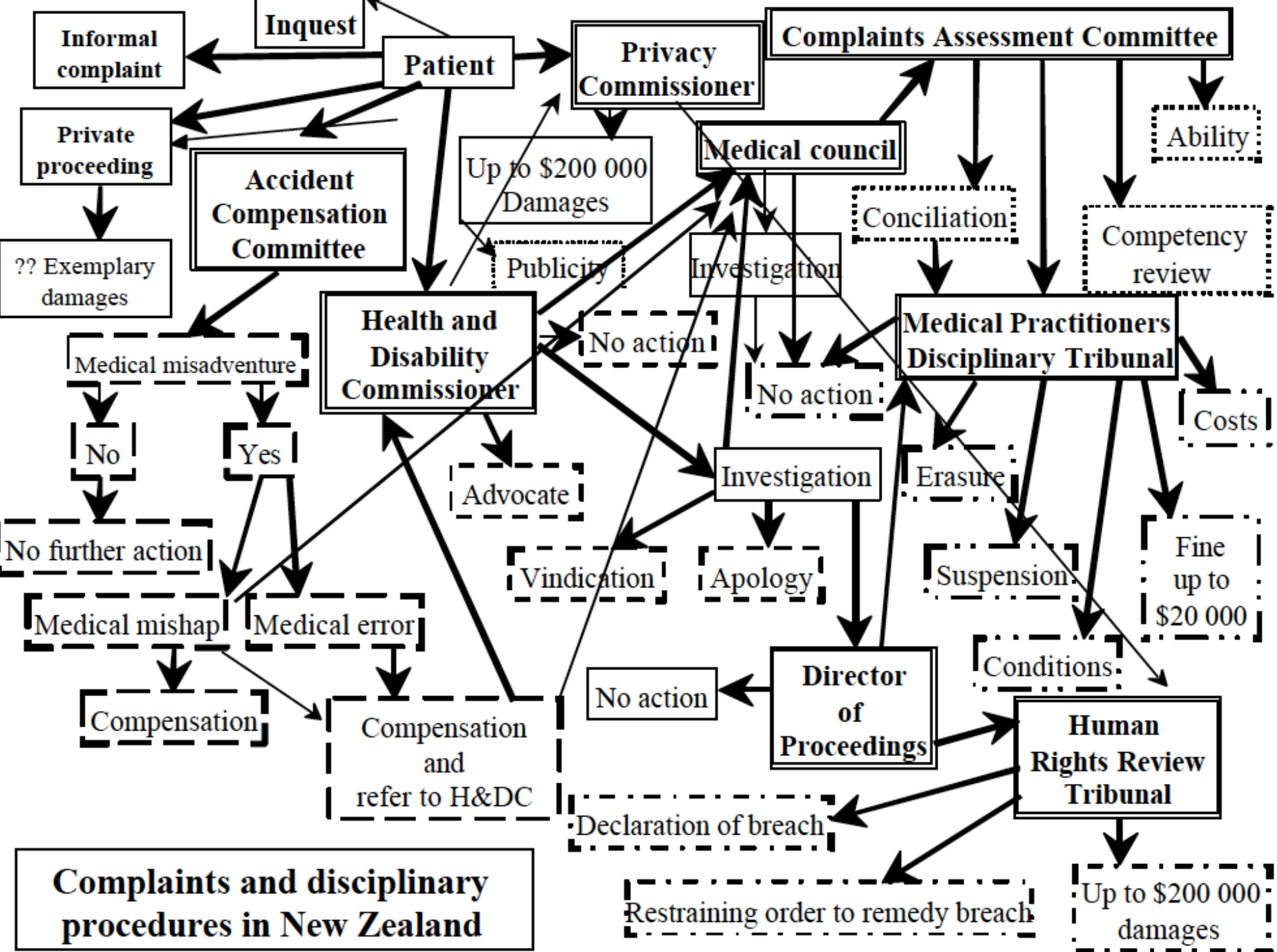
Exclusive: Clinical failings with catastrophic consequences repeated over period of nearly 40 years, resulting in avoidable deaths, serious injuries and then further trauma subsequently inflicted on grieving families

The Shrewsbury investigation revealed repeated clinical errors were compounded by substandard follow-up investigations that failed to ensure lessons were learnt, while bereaved families were treated with “a distinct lack of kindness and respect”.

Staff referred to deceased babies as “it”, or got their names wrong, while many grieving parents were told their case was the only one of its kind.

On one occasion, a baby’s body was allowed to decompose over a period of weeks after a post-mortem examination, reaching such a point it prevented the mother seeing her child one final time before burial.

Why do we see this repeated lack of basic compassion, empathy and care?





Multiple Jeopardy

Prolonged Time Scale

Not judged by peers
Incompetence, poor
process, lack of
experience

Guilty until proved
innocent

Contrary to Natural
Justice

BMJ Open The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey

To cite: Bourne T, Wynants L, Peters M, *et al.* The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. *BMJ Open* 2015;**4**:e006687. doi:10.1136/bmjopen-2014-006687

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“A NO BLAME CULTURE”

IMPACT study - in brief

- 95,600 members of BMA invited to complete survey on their health, welfare and clinical practice – 10,930 responses (11.4%)
- 7,926 completed the survey (8.3%)
- Respondents guaranteed that responses were anonymous & untraceable.

IMPACT study: design

Three groups depending on timing of the complaint

- Ongoing or recent complaint (within last 6 months), assess current wellbeing and attitudes
- Past complaint (over 6 months), asked to recall physical and mental health at the time
- No complaint – but had observed processes in others so not a true “control group”

Used Validated Instruments

- **ANXIETY:** Generalised Anxiety Disorder scale-GAD
- **DEPRESSION:** Patient Health Questionnaire-PHQ
- **DEFENSIVE PRACTICE** - New scale measuring two factors:
 - **HEDGING**
 - including over referral/prescribing/investigating/admitting to hospital when unnecessary
 - **AVOIDANCE**
 - including not performing high-risk procedures, stopping certain activities e.g. surgery, avoiding complex patients, abandoning procedures early

SINGLE ITEM QUESTIONS:

- Stress related illness
- Suicidal ideation
- Attitude to complaints

Results by type of process for current complaints using validated instruments: how they feel now

	Informal complaint n=362 (16.0%)	Formal Complaint n=1196 (53.0%)	SUI n=280 (12.4%)	GMC referral n=374 (16.6%)	No complaint n=1780 (22.5%)
Depression (PHQ-9)					
Mean (SD) ^a	4.2 (5.0)	4.8 (5.4)	5.1 (5.6)	6.6 (6.7)	3.7 (4.3)
Moderate to severe depression n (%)	45 (12.0%)	190 (15.6%)	46 (16.1%)	100 (26.3%)	169 (9.5%)
Thoughts of 'self- harm' n (%)	24 (6.4%)	110 (9.0%)	27 (9.3%)	58 (15.3%)	83 (4.7%)
Anxiety (GAD-7)					
Mean (SD) ^b	3.8 (4.3)	4.4 (4.7)	4.7 (5.1)	5.7 (5.7)	3.1 (3.8)
Moderate to severe anxiety n (%)	44 (12.0%)	165 (13.5%)	44 (15.3%)	85 (22.3%)	131 (7.3%)

2013-2014 175,000 formal written complaints (3300/week or 479/day)

Single item questions – recalling how they felt (past - > 6 months) and how they feel (current complaint)

	No complaint n=1780 (22.5%)	Recent or current complaint n=2257 (28.5%)	Past complaint n=3889 (49.1%)	RR
Cardio-vascular problems (e.g. high blood pressure, angina, heart attack)	124 (7.0%)	280 (12.4%)	405 (10.4%)	1.78 (1.44-2.20)
Gastro-intestinal problems (e.g. gastritis, IBS, ulcers)	217 (12.2%)	426 (18.9%)	934 (24.0%)	1.55 (1.32-1.82)
Depression	187 (10.5%)	490 (21.7%)	1148 (29.5%)	2.07 (1.74-2.45)
Anxiety	476 (26.7%)	1108 (49.1%)	3045 (78.3%)	1.84 (1.65-2.04)
Anger and irritability	358 (20.1%)	928 (41.1%)	2406 (61.9%)	2.04 (1.77-2.35)
Other mental health problems	12 (0.7%)	54 (2.4%)	256 (6.6%)	3.45 (1.80-6.60)
Suicidal thoughts	44 (2.5%)	211 (9.3%)	519 (13.4%)	3.78 (2.68-5.32)
Sleep problems / insomnia	479 (26.9%)	1137 (50.4%)	288 (74.1%)	1.87 (1.67-2.10)
Relationship problems	187 (10.5%)	458 (20.3%)	911 (23.4%)	1.94 (1.63-2.30)
Frequent headaches	242 (13.6%)	432 (19.2%)	1027 (26.4%)	1.41 (1.19-1.65)
Minor colds	492 (27.6%)	509 (22.5%)	5447 (14.0%)	0.82 (0.73-0.92)
Recurring respiratory infections	77 (4.3%)	143 (6.3%)	306 (7.9%)	1.47 (1.11-1.95)

Does all this improve patient care?

Because of your/other's experiences with complaints, have you....	No complaint n=1780 (22.5%)	Past complaint n=3889 (49.1%)	Recent or current complaint n=2257 (28.5%)	Total n=7926 (100%)	Relative Risk for past complaint (95% CI)	Relative Risk for recent or current complaint (95% CI)
Changed the way of practicing medicine n (%)	1294 (72.7%)	3106 (79.9%)	1912 (84.7%)	6312 (79.6%)	1.10 (1.06,1.14)	1.17 (1.13,1.21)
Displayed hedging behaviour n (%)	1454 (81.7%)	3212 (82.6%)	1999 (88.6%)	6665 (84.1%)	1.01 (0.98,1.04)	1.08 (1.05,1.11)
Displayed avoiding behaviour n (%)	820 (46.1%)	1668 (42.9%)	1124 (49.8%)	3612 (45.6%)	0.93 (0.87,1.00)	1.08 (1.00,1.17)
Suggested invasive procedures against professional judgement n (%)	359 (20.2%)	902 (23.2%)	585 (25.9%)	1846 (23.3%)	1.15 (1.02,1.29)	1.29 (1.13,1.46)
Become more likely to abandon a procedure at an early stage n (%)	248 (14.0%)	515 (13.3%)	372 (16.5%)	1136 (14.3%)	0.95 (0.80,1.13)	1.18 (1.00,1.39)
Become less committed and worked strictly to job description n (%)	-	795 (20.5%)	613 (27.2%)		-	-

BMJ Open Doctors' experiences and their perception of the most stressful aspects of complaints processes in the UK: an analysis of qualitative survey data

To cite: Bourne T, Vanderhaegen J, Vranken R, *et al.* Doctors' experiences and their perception of the most stressful aspects of complaints processes in the UK: an analysis of qualitative survey data. *BMJ Open* 2016;**6**:e011711. doi:10.1136/bmjopen-2016-011711

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Qualitative data – 3 “Open” Questions

- Q1 “Try to summarise as best you can your experience of the complaints process and how it made you feel”
- Q2 “What were the most stressful aspects of the complaint?”
- Q3 “What would you improve in the complaints system?”

Qualitative data – what did doctors say

I felt victimised, isolated and that no one even bothered to listen to what I had to say. I had 3 young children and a single parent and frequently felt like harming myself.

I found it terrifying

When the letter came I was on a weeks annual leave at home and almost took my own life.

It felt like it destroyed me as a person, not only in my working role. I have recovered to some extent but it will always scar me.

I felt I was raped by the system and completely let down.

If it was not for the support of some fantastic friends I would probably have committed suicide at one point. It has taken me years to get over the experience

As a result of the negative media coverage my son was physically assaulted by a class mate at university as he got academic scholarships and was told that his mother:

“got all the benefits that this country offered whilst in reality your f..king Mother is a f..king Killer of babies”

I also got my second episode of breast cancer during this period.

- Fear is Toxic to patient safety
 - Abandon blame as a tool

'Largest maternity scandal in NHS history': Dozens of mothers and babies died on wards of hospital trust, leaked report reveals

Exclusive: Clinical failings with catastrophic consequences repeated over period of nearly 40 years, resulting in avoidable deaths, serious injuries and then further trauma subsequently inflicted on grieving families



Learning from Bristol:

The Department of Health's Response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995

Cm 5363

The Report of the Morecambe Bay Investigation

Dr Bill Kirkup CBE

March 2015

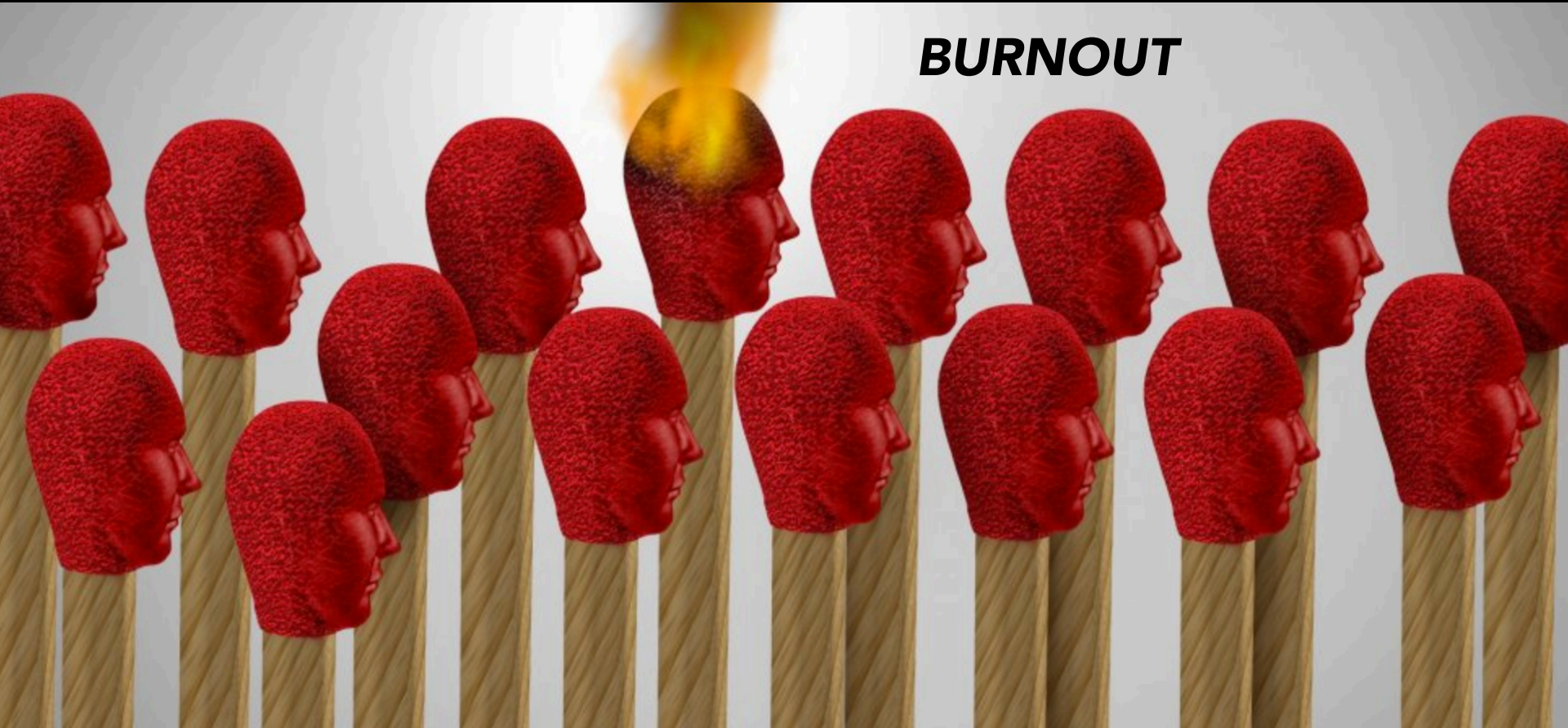
The Report of the Shrewsbury and Telford Investigation

Donna Ockenden

ch 2015

What makes doctors who start off with good intentions stop caring?

BURNOUT



Burnout definition by WHO

ICD-11 2019 Code QD85 (May 2019)

“Burnout is a syndrome conceptualised as resulting from **chronic workplace stress that has not been successfully managed.**

Characterised by three dimensions:

1. Emotional Exhaustion - feelings of energy depletion or exhaustion
2. Depersonalisation - Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job
3. Reduced personal accomplishment/professional efficacy

Burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life.”

Three Subscales for Burnout

→ **Emotional Exhaustion:**

Generalized fatigue that can be related to devoting excessive time and effort to a task or project that is not perceived to be beneficial (e.g. EPR in the States). For example, a feeling of exhaustion, particularly emotional exhaustion, may be caused by continuing to care for a patient who has a very poor chance of recovery.

Depersonalisation

A distant or indifferent attitude towards work.

Depersonalization manifests as negative, callous, and cynical behaviors; or interacting with colleagues or patients in an impersonal manner.

Unprofessional comments directed toward co-workers, blaming patients for their medical problems, or the inability to express empathy or grief when a patient dies.

→ **Reduced personal accomplishment**

Tendency to negatively evaluate the worth of one's work, feeling insufficient in regard to the ability to perform one's job, and a generalized poor professional self-esteem.

What is the scale of the problem?

Open access

Original research

BMJ Open Burnout, well-being and defensive medical practice among obstetricians and gynaecologists in the UK: cross-sectional survey study

To cite: Bourne T, Shah H, Falconieri N, *et al.* Burnout, well-being and defensive medical practice among obstetricians and gynaecologists in the UK: cross-sectional survey study. *BMJ Open* 2019;**9**:e030968. doi:10.1136/bmjopen-2019-030968

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Bourne T, *et al.* *BMJ Open* 2019;**9**:e030968. doi:10.1136/bmjopen-2019-030968

Study Aims

- Ascertain the prevalence of burnout in the cohort
- Determine the levels of defensive medical practice (DMP) and doctor wellbeing in the cohort
- Explore if there is any association between burnout, DMP and wellbeing
- Explore the relationships (if any) between age, gender, ethnicity, grade (consultant, staff grade, trainee) and both burnout and DMP

Design & Methods

- Nationwide online cross-sectional survey study (Dec 17 – Mar 18)
Sent as part of RCOG Workforce and Welfare Survey
- Answers all guaranteed to be anonymous
- 5661 practising Obstetrics and Gynaecology (O&G) consultants, specialty and associate specialist (SAS) doctors and trainees registered with the RCOG were invited to participate

Outcome Measure – Burnout

Maslach Burnout Inventory (MBI)¹

- Validated 22-item tool to identify and characterise burnout
- 3 subscales to evaluate the 3 domains of burnout
 - Emotional exhaustion (EE). Scores of ≥ 27 (range 0-54) are considered high/poor
 - Depersonalisation (DP). Scores of ≥ 10 (range 0-30) are considered high or poor
 - Low personal accomplishment (PA). Scores ≤ 33 (range is 0-48) are defined as low/poor

Burnout defined as high EE and/or DP score as per convention²

1. Maslach C, Jackson SE. The measurement of experienced burnout. J Organ Behav. 1981;2(2):99-113.

2. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. J Intern Med. 2018;283(6):516-29.

Defensive Practice (DMP)

Assessed based on the IMPACT Study (Bourne et al 2015 BMJ Open)¹

- 12-item questionnaire assessing 2 subscales

- 'Avoidance' - includes not taking on complicated patients, avoiding or abandoning difficult procedures and/or cases. Scores of ≥ 5 (range 0-12) are considered as elevated avoidance behaviour
- 'Hedging' – when doctors are overcautious, leading to overprescribing/over-investigation/over-admitting/ over investigating/ over referral. Scores of ≥ 13 (range 0-36) are considered as elevated hedging behaviour

We defined any DMP as having elevated levels of avoidance and/or hedging.

1. Bourne T, Wynants L, Peters M, Van Audenhove C, Timmerman D, Van Calster B, et al. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. BMJ Open. 2015;5(1):e006687.

Wellbeing

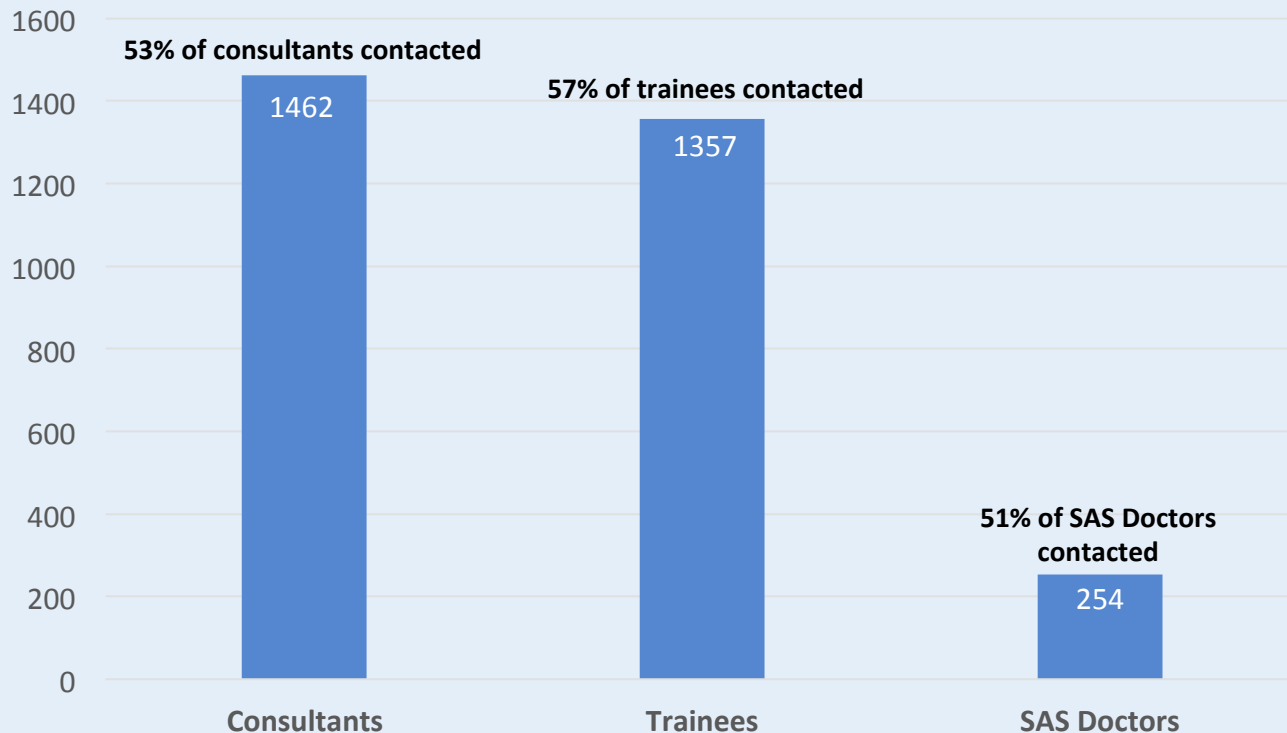
Doctors were asked to self-report on a variety of common medical illnesses:

- Cardiovascular problems
- Gastro-intestinal problems
- Depression
- Anxiety
- Anger and irritability
- Suicidal thoughts
- Sleep problems
- Relationship problems
- Headaches
- Minor colds
- Recurring respiratory infections
- Alcohol/drug misuse

Results – Response Rate

55% (3102/5661) of doctors completed the survey

99% (3073) met the inclusion criteria (Actively practising/sick leave/maternity leave)



RESULTS	Consultants N=1481	SAS Trust N=257	Trainees N=1364
Actively practicing	1462 (99%)	254 (99%)	1357 (99%)
Maslach Burnout Inventory			
Emotional exhaustion			
Mean	2.2 (0-6)	2.1 (0-5.9)	2.4 (0-6)
Poor, %	411 (28%)	65 (26%)	440 (32%)
Depersonalization			
Mean	0.9 (0-5.8)	0.9 (0-6)	1.4 (0-5.8)
Poor, %	178 (12%)	33 (13%)	394 (29%)
Personal accomplishment			
Mean	4.7 (1-6)	4.4 (0.5-6)	4.3 (0-6)
Poor, %	382 (26%)	95 (37%)	530 (39%)
Burnout	460 (31%)	76 (30%)	580 (43%)
Defensive practice			
Avoidance			
Mean	1.4 (0-12)	1.1 (0-12)	0.9 (0-10)
Elevated, %	125 (9%)	13 (5%)	58 (4%)
Hedging			
Mean	5.2 (0-36)	2.8 (0-36)	4.6 (0-36)
Elevated, %	164 (11%)	11 (4%)	114 (8%)
Any defensive practice	231 (16%)	20 (8%)	149 (11%)

36% of doctors overall met the criteria for burnout (1116/3073)

Levels highest amongst trainees - 43%

Levels amongst consultants – 31%

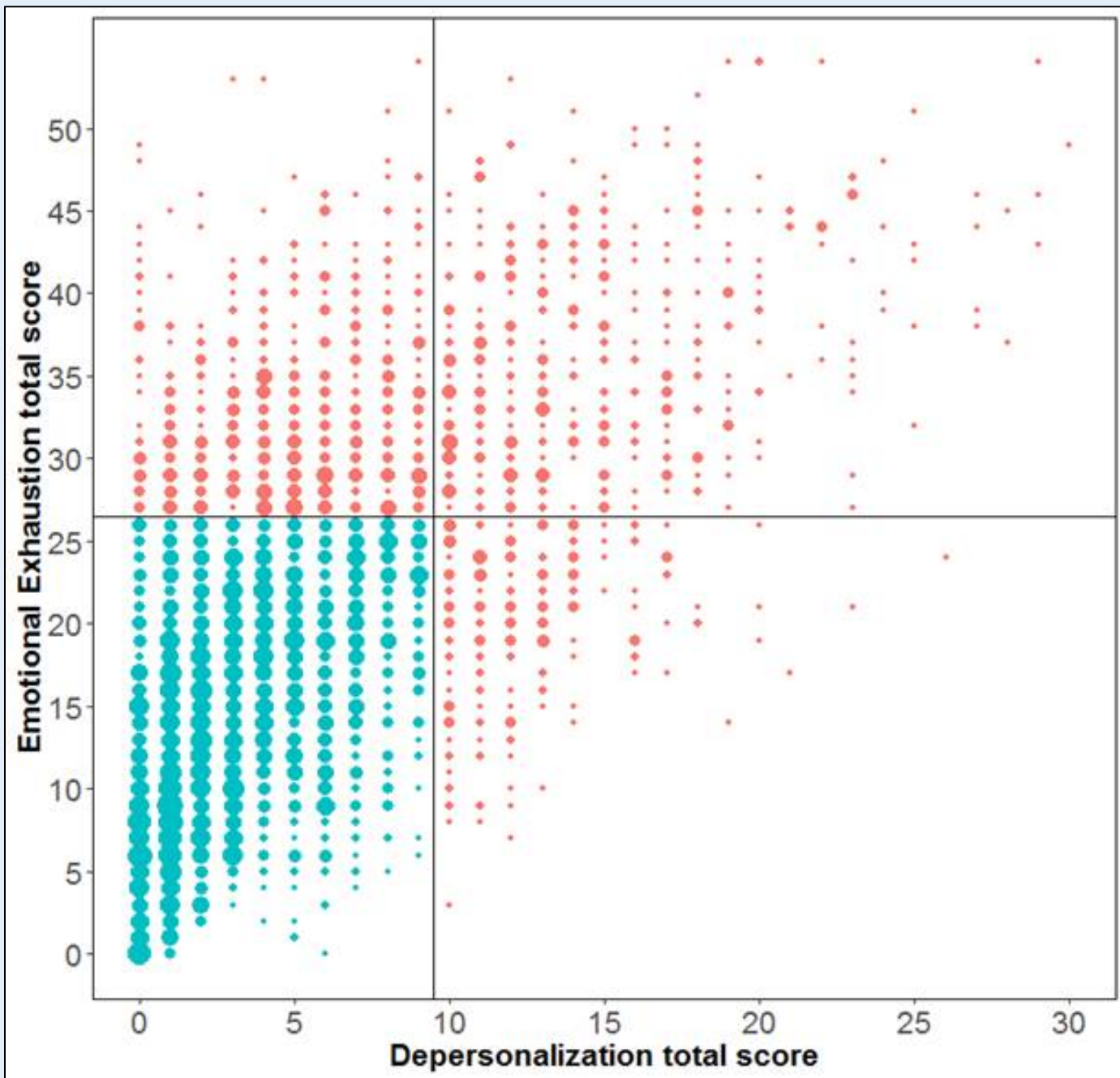
Increased defensive practice observed in 13% of doctors overall

Levels highest in consultants (16%)

Descriptive statistics of defensive practice by burnout status

Doctor category	Avoidance	Hedging	Any DMP
Burnout status	% Elevated	% Elevated	%
All doctors			
No burnout (n=1957)	71 (4%)	94 (5%)	142 (7%)
Burnout (n=1116)	125 (11%)	195 (17%)	258 (23%)
Odds ratio (95% CI)	3.34 (2.48-4.53)	4.18 (3.24-5.43)	3.84 (3.08-4.79)

23% (258/1116) of doctors with burnout reported increased DMP
(avoiding cases/procedures or overprescribing/over-referral)
compared to 7% (142/1957) without burnout.



Descriptive statistics of defensive practice by MBI subscale

BMI subscales	Avoidance		Hedging		Any DMP
	Mean	% Elevated	Mean	% Elevated	%
High emotional exhaustion					
No (n=2157)	0.88	85 (4%)	3.76	125 (6%)	179 (8%)
Yes (n=916)	1.82	111 (12%)	7.05	164 (18%)	221 (24%)
High depersonalization					
No (n=2468)	0.95	106 (4%)	3.93	159 (6%)	229 (9%)
Yes (n=605)	2.02	90 (15%)	8.06	130 (21%)	171 (28%)
Low personal accomplishment					
No (n=2066)	0.97	103 (5%)	4.19	142 (7%)	202 (10%)
Yes (n=1007)	1.55	93 (9%)	5.87	147 (15%)	198 (20%)

Association between Burnout and Wellbeing

Doctors with burnout had a higher prevalence of self-reported medical illness

Highest OR: suicidal thoughts (6.37), depression (4.05), anxiety (3.59) and anger/irritability (3.51)

13.5% of all doctors reported depression

7.4% for doctors without burnout

24.4% (1 in 4) for doctors with burnout

2.9% of all doctors reported suicidal thoughts

1.0% among doctors without burnout

6.3% (1 in 16) among doctors with burnout

	All (n=3073)	Consultants (n=1462)	SAS ^a (n=254)	Trainees (n=1357)
Cardiovascular problems	261 (8.5)	186 (12.7)	31 (12.2)	44 (3.2)
No burnout	148 (7.6)	114 (11.4)	20 (11.2)	14 (1.8)
Burnout ^b	113 (10.1)	72 (15.7)	11 (14.5)	30 (5.2)
Odds ratio ^c (95% CI)	1.38 (1.07-1.78)			
Gastro-intestinal problems	480 (15.6)	221 (15.1)	29 (11.4)	230 (16.9)
No burnout	225 (11.5)	111 (11.1)	14 (7.9)	100 (12.9)
Burnout	255 (22.8)	110 (23.9)	15 (19.7)	130 (22.4)
Odds ratio ^c (95% CI)	2.28 (1.87-2.78)			
Depression	416 (13.5)	141 (9.6)	41 (16.1)	234 (17.2)
No burnout	144 (7.4)	42 (4.2)	21 (11.8)	81 (10.4)
Burnout	272 (24.4)	99 (21.5)	20 (26.3)	153 (26.4)
Odds ratio ^c (95% CI)	4.05 (3.26-5.04)			
Anxiety	1008 (32.8)	416 (28.5)	80 (31.5)	512 (37.7)
No burnout	439 (22.4)	194 (19.4)	43 (24.2)	202 (26.0)
Burnout	569 (51.0)	222 (48.3)	37 (48.7)	310 (53.4)
Odds ratio ^c (95% CI)	3.59 (3.07-4.21)			
Anger-irritability	1048 (34.1)	498 (34.1)	81 (31.9)	469 (34.6)
No burnout	465 (23.8)	235 (23.5)	42 (23.6)	188 (24.2)
Burnout	583 (52.2)	263 (57.2)	39 (51.3)	281 (48.4)
Odds ratio ^c (95% CI)	3.51 (3.00-4.10)			
Suicidal thoughts	90 (2.9)	33 (2.3)	2 (0.8)	55 (4.1)
No burnout	20 (1.0)	5 (0.5)	0	15 (1.9)
Burnout	70 (6.3)	28 (6.1)	2 (2.6)	40 (6.9)
Odds ratio ^c (95% CI)	6.37 (3.95-10.7)			
Sleep problems / insomnia	1188 (38.7)	515 (35.2)	93 (36.6)	580 (42.7)
No burnout	563 (28.8)	256 (25.5)	52 (29.2)	255 (32.8)
Burnout	625 (56.0)	259 (56.3)	41 (53.9)	325 (56.0)
Odds ratio ^c (95% CI)	3.15 (2.70-3.67)			
Marital/relationship problems	544 (17.7)	206 (14.1)	43 (16.9)	295 (21.7)
No burnout	241 (12.3)	105 (10.5)	20 (11.2)	116 (14.9)
Burnout	303 (27.2)	101 (22.0)	23 (30.3)	179 (30.9)
Odds ratio ^c (95% CI)	2.65 (2.20-3.20)			
Frequent headaches	652 (21.2)	210 (14.4)	77 (30.3)	365 (26.9)
No burnout	317 (16.2)	107 (10.7)	37 (20.8)	173 (22.3)
Burnout	335 (30.0)	103 (22.4)	40 (52.6)	192 (33.1)
Odds ratio ^c (95% CI)	2.22 (1.86-2.64)			
Minor colds	812 (26.4)	268 (18.3)	59 (23.2)	485 (35.7)
No burnout	449 (22.9)	165 (16.5)	42 (23.6)	242 (31.1)
Burnout	363 (32.5)	103 (22.4)	17 (22.4)	243 (41.9)
Odds ratio ^c (95% CI)	1.62 (1.37-1.91)			
Recurrent respiratory infections	188 (6.1)	66 (4.5)	16 (6.3)	106 (7.8)
No burnout	81 (4.1)	31 (3.1)	10 (5.6)	40 (5.1)
Burnout	107 (9.6)	35 (7.6)	6 (7.9)	66 (11.4)
Odds ratio ^c (95% CI)	2.45 (1.82-3.31)			
Alcohol/drugs problems	97 (3.2)	56 (3.8)	4 (1.6)	37 (2.7)
No burnout	40 (2.0)	24 (2.4)	2 (1.1)	14 (1.8)
Burnout	57 (5.1)	32 (7.0)	2 (2.6)	23 (4.0)
Odds ratio ^c (95% CI)	2.57 (1.71-3.89)			

Association between Doctor Characteristics and Burnout or Defensive Practice

Factors most strongly related with burnout:

- Being of younger age (<35)
- White or 'other' ethnicity
- Graduating with a medical degree from the UK/Ireland

	Burnout (%)	Any DMP (%)
Age (years)		
<35 (n=948)	440 (46%)	115 (12%)
35-49 (n=1209)	395 (33%)	151 (12%)
≥50 (n=916)	281 (31%)	134 (15%)
Gender		
Female (n=2069)	763 (37%)	239 (12%)
Male (n=963)	332 (34%)	152 (16%)
Ethnicity		
White (n=1767)	723 (41%)	227 (13%)
Asian (n=832)	229 (28%)	105 (13%)
Black (n=201)	57 (28%)	21 (10%)
Mixed (n=172)	59 (34%)	31 (18%)
Other (n=82)	39 (48%)	8 (10%)
Parity		
No (n=1023)	473 (46%)	126 (12%)
Yes (n=2050)	643 (31%)	274 (13%)
Relationship		
No (n=601)	266 (44%)	74 (12%)
Yes (n=2464)	844 (34%)	323 (13%)
Country of Qualification		
United Kingdom/Ireland (n=1996)	841 (42%)	265 (13%)
Other (n=1075)	273 (25%)	135 (13%)
Work status		
Full Time (n= 2551)	952 (37%)	341 (13%)
Less Than Full Time (n=519)	163 (31%)	59 (11%)
Subspecialty (consultants)		
None (n=1278)	404 (32%)	213 (17%)
Maternal/Fetal (n=56)	20 (36%)	8 (14%)
Sexual/Reproductive health (n=34)	10 (29%)	1 (3%)
Gynaecological oncology (n=33)	8 (24%)	1 (3%)
Reproductive medicine (n=33)	9 (27%)	2 (6%)
Urogynaecology (n=28)	9 (32%)	6 (21%)

Summary

- 43% of trainees, 31% of consultants and 30% of SAS doctors in O&G suffer from burnout using the MBI.
- Burnout is associated with suicidal ideation, depression, anxiety, anger and irritability, marital/relationship problems, sleep/insomnia, alcohol and drug abuse
- We have shown that burnout is associated with higher levels of defensive medical practice
- Age is inversely associated with burnout – with higher rates of burnout already seen in trainees.
- Doctors who graduated in the UK/Ireland are almost twice as likely to experience burnout whereas doctors from ethnic minorities were less likely to experience burnout, after controlling for other confounding variables
- **WHAT IS THE POTENTIAL SIGNIFICANCE OF THIS STUDY ?**

Jeremy Hunt at the Kings Fund in 2012

"The most worrying thing is the fact that in certain institutions this kind of care appears to have become normal," he said at the time. "In places that should be devoted to patients, where compassion should be uppermost, we find its very opposite: a coldness, resentment, indifference, even contempt. Go deeper and look at the worst cases like Mid Staffs and Winterbourne View, and there is something even darker: a kind of normalisation of cruelty where the unacceptable is legitimised and the callous becomes mundane."

One in three maternity doctors in the UK are 'burnt out' and at risk of making harmful mistakes, study warns

- More than one in three maternity doctors admitted they suffer from burnout
- Makes them care less about patients and their job, increasing risk of mistakes
- Means they avoid difficult cases and over-prescribe medications for ease

By [CONNOR BOYD](#) HEALTH REPORTER FOR MAILONLINE

PUBLISHED: 11:21, 26 November 2019 | **UPDATED:** 13:43, 26 November 2019

'WORRYING' New mums and babies are put at risk of poor care by stressed out medics, study warns

Nick McDermott, Health Editor

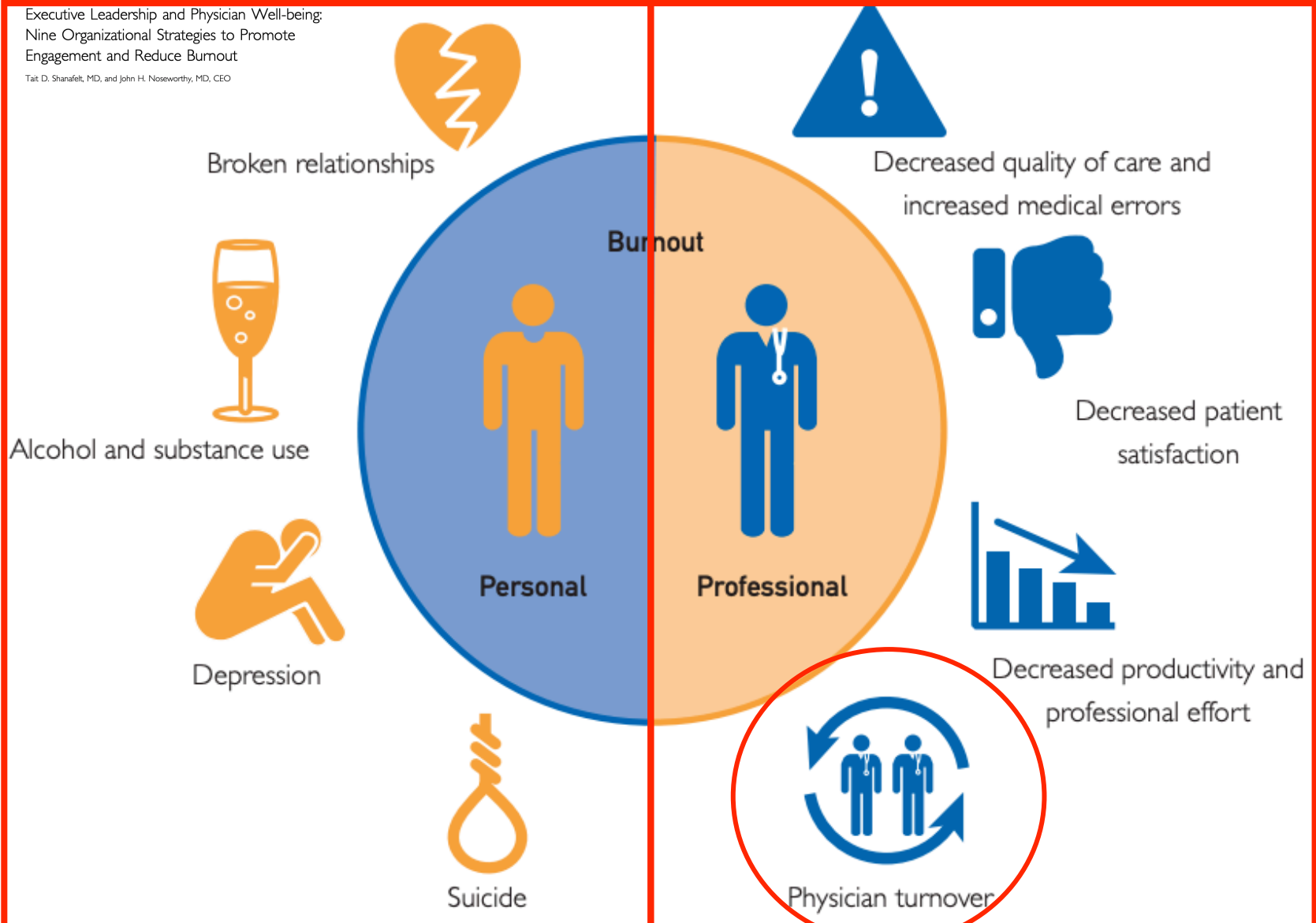
26 Nov 2019, 0:25 | Updated: 26 Nov 2019, 0:25

The findings follow the revelations last week that dozens of babies and several mums died amid major failings at a hospital trust. In the biggest maternity scandal in NHS history, blundering doctors, midwives and bosses worked unchecked in a "toxic" culture at Shrewsbury and Telford Hospital Trust for 40 years.

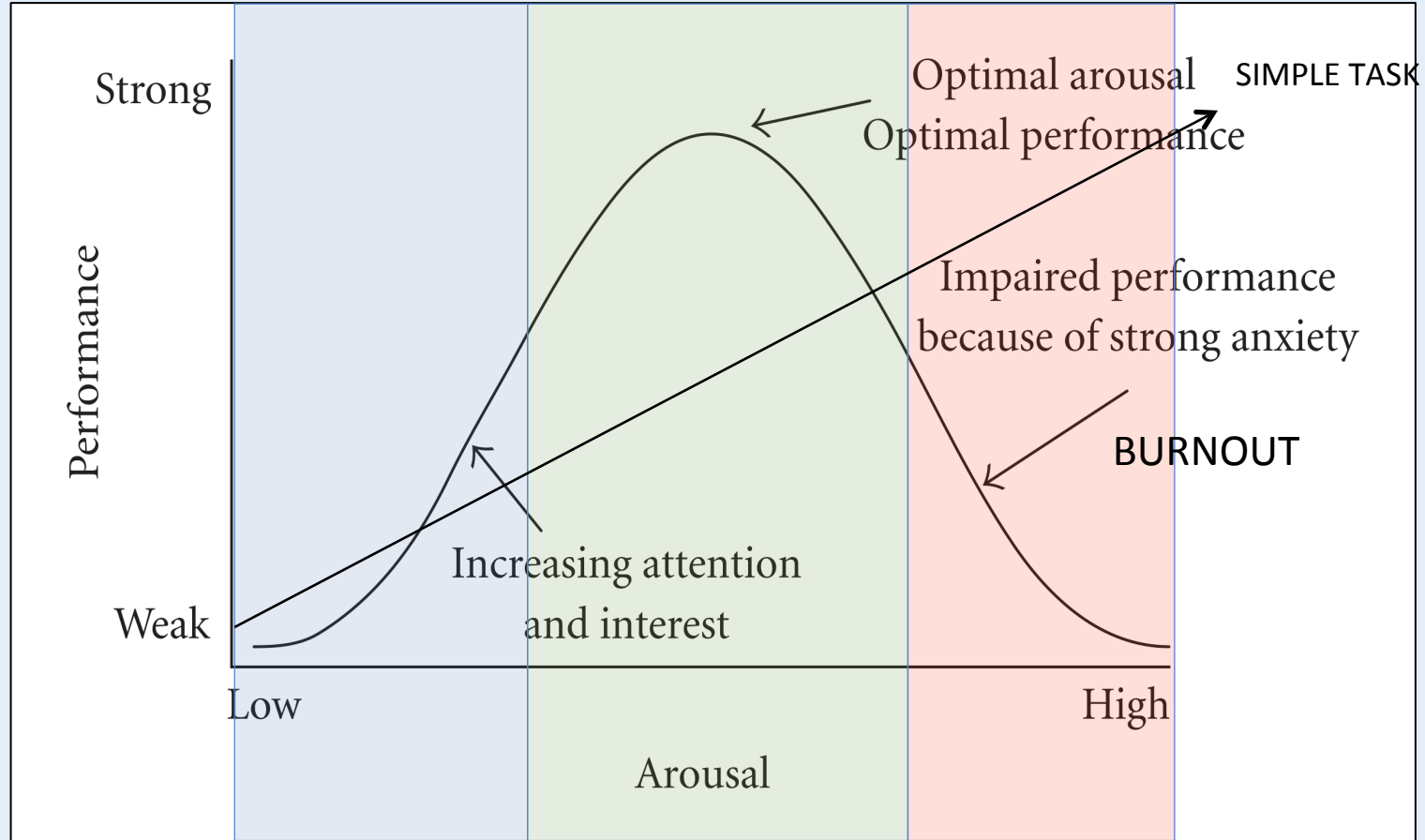
Why Does Burnout Matter

Executive Leadership and Physician Well-being:
Nine Organizational Strategies to Promote
Engagement and Reduce Burnout

Tait D. Shanafelt, MD, and John H. Noseworthy, MD, CEO



Modified Yerkes Dodson Curves



Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction

A Systematic Review and Meta-analysis

Maria Panagioti, PhD; Keith Geraghty, PhD; Judith Johnson, PhD; Anli Zhou, MD; Efharis Panagopoulou, PhD; Carolyn Chew-Graham, MD; David Peters, MD; Alexander Hodgkinson, PhD; Ruth Riley, PhD; Aneez Esmail, MD, PhD

Key Points

JAMA Intern Med. doi:10.1001/jamainternmed.2018.3713
Published online September 4, 2018.

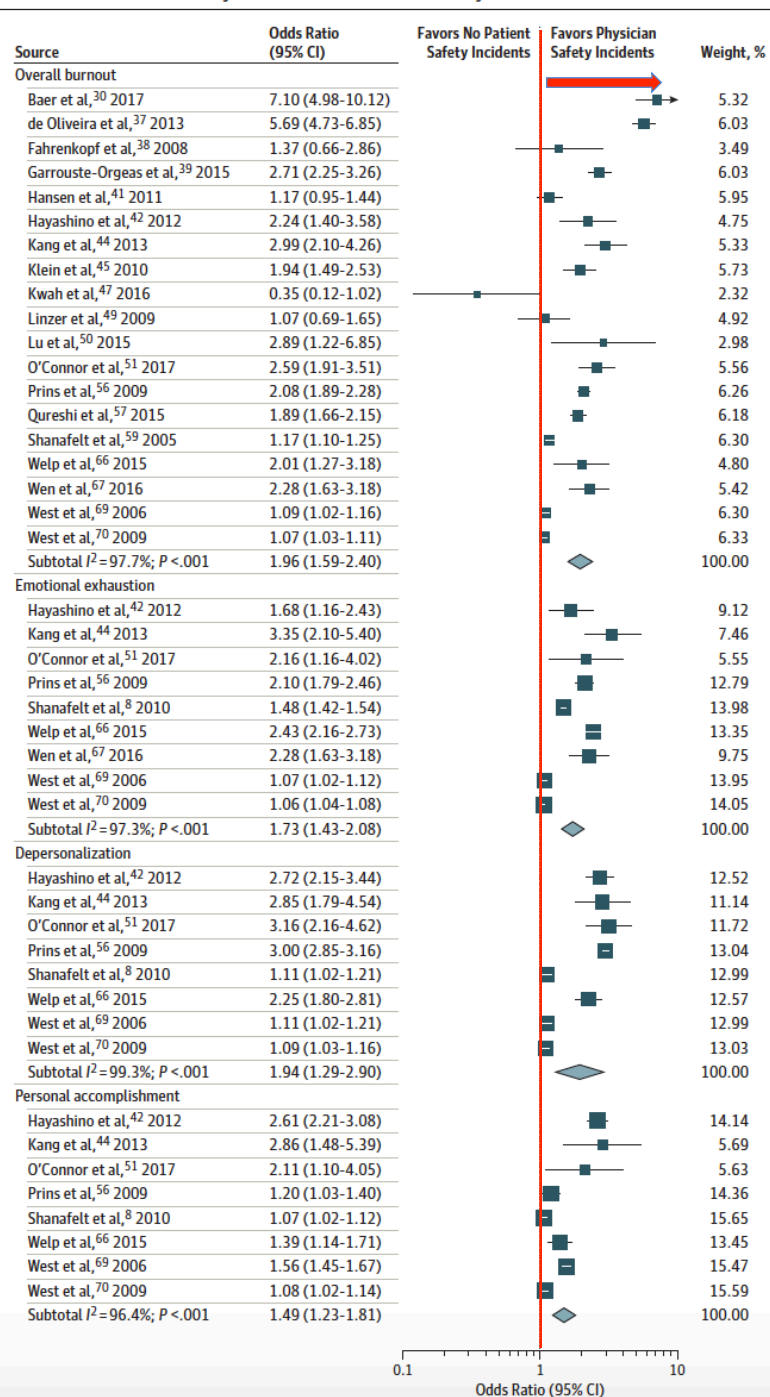
Question Is physician burnout associated with low-quality, unsafe patient care?

Findings This meta-analysis of 47 studies on 42 473 physicians found that burnout is associated with 2-fold increased odds for unsafe care, unprofessional behaviors, and low patient satisfaction. The depersonalization dimension of burnout had the strongest links with these outcomes; the association between unprofessionalism and burnout was particularly high across studies of early-career physicians.

Meaning Physician burnout is associated with suboptimal patient care and professional inefficiencies; health care organizations have a duty to jointly improve these core and complementary facets of their function.

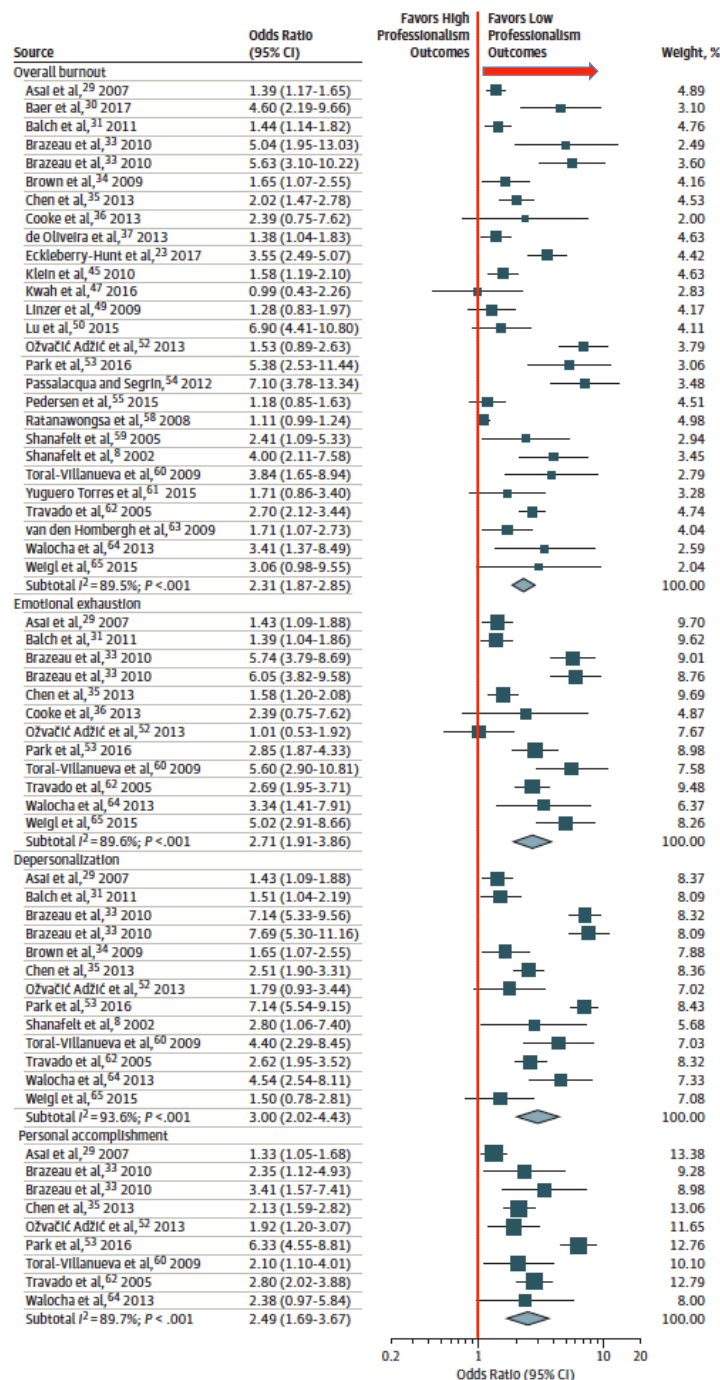
Burnout and Patient Safety Incidents

Figure 2. Association Between Physician Burnout and Patient Safety Incidents



Burnout and Low Professionalism (lack of empathy, Poor relationships)

Figure 3. Forest Plot of the Association Between Physician Burnout and Low Professionalism Outcomes



Potential Risk factors for Burnout

Individual risk factors: <ul style="list-style-type: none">• having poor self-esteem• maladaptive coping mechanisms• younger adults with an idealistic worldview• unrealistically high expectations• having financial issues	Organizational risk factors: <ul style="list-style-type: none">• heavy workload• conflicts with coworkers• diminished resources• lack of control or input• effort-reward imbalance• understaffing• rapid institutional changes
<ul style="list-style-type: none">• variability in work schedules• rapid turnover of patients• end-of-life events	TRAINEE DOCTORS

Caring for the mental health of the medical workforce

Key principles to improving mental health among doctors and medical students

Building a supportive culture

- **Valuing the NHS workforce:** promoting shared values, fostering a sense of fulfilment and enjoyment at work, involving staff in mental health policy design, procedure and implementation, offering adjustments (time off, reduced hours)
- **Preventing the cause of ill-health:** reducing risks and pressures, fostering a no-blame environment
- **Raising mental health awareness:** addressing the stigma around accessing support services, normalising and encouraging help-seeking behaviour, offering education/training opportunities to improve awareness, creating mental health champions
- **Using innovation and best practice:** being proactive in providing support and designing strategies to improve mental health
- **Offering support:** recognising and providing support for potentially stressful events/situations (traumatic incidents, career transitions), training supervisors/educators to help/signpost to services



British Medical Association
bma.org.uk

Used Oldenburg Burnout
Inventory (OLBI) 2019



National Academy of Medicine

Action Collaborative on Clinician Well-Being and Resilience

Clinician well-being is essential for safe, high-quality patient care.

However, clinicians of all kinds, across all specialties and care settings, are experiencing alarming rates of burnout. Among the most telling of statistics, more than 50 percent of U.S. physicians report significant symptoms. Burnout is a syndrome characterized by a high degree of emotional exhaustion and depersonalization (i.e., cynicism), and a low sense of personal accomplishment at work.

Quick Links

[Clinician Well-Being Knowledge Hub](#)[NEW! Case Studies](#)[Resources](#)

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WELLMD CENTER

The **Stanford Medicine WellMD Center** was created in late 2015 and jointly funded by the School of Medicine, Stanford Health Care and Stanford Children's Health.

Contact: wellmdcenter@stanford.edu

Mission Statement:

"To advance the well-being of physicians and those they serve."

WellMD Professional Fulfillment Model:

- **Culture of Wellness**

Shared values, behaviors, and leadership qualities that prioritize personal and professional growth, community, and compassion for self and others.

- **Efficiency of Practice**

Workplace systems, processes, and practices that promote safety, quality, effectiveness, positive patient and colleague interactions, and work-life balance.

- **Personal Resilience**

Individual skills, behaviors, and attitudes that contribute to physical, emotional, and professional well-being.

[WellMD Professional Fulfillment Model](#)



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[WellMD 2017 Status Report](#)

Governance

[Organizational Chart](#)

Center Leadership:



Dr. Tait Shanafelt

Center
Director,
Chief Wellness
Officer



Dr. Mickey Trockel

Director,
Scholarship
and Health
Promotion

The New York Times

Strong leaders are not only good for patients, but also for doctors, as a [program from the Mayo Clinic illustrates](#). Each year, clinicians at Mayo assess their supervisors — all of whom are physicians — on a Leader Index, a simple 12-question survey of five leadership domains: truthfulness, transparency, character, capability and partnership. Does the physician-leader support colleagues? Are they approachable and fair? Do others feel psychologically safe working with them?

The results have been impressive. For every one-point increase in a leader's score, there is a 9 percent improvement in professional satisfaction and a 4 percent decrease in burnout among frontline doctors. Across departments, *nearly half* of the variation in satisfaction can be explained by the Leader Index score of the chairperson.

Burnout in healthcare: the case for organisational change

Burnout is an occupational phenomenon and we need to look beyond the individual to find effective solutions, argue **A Montgomery and colleagues**

A Montgomery professor in work and organizational psychology¹, E Panagopoulou associate professor², A Esmail professor of general practice³, T Richards senior editor, BMJ patient partnership initiative⁴, C Maslach professor⁵

Organisations are designed and managed around work teams, and managers are held accountable for large groups of people. The relevant data for evaluating these teams are typically aggregated indicators, such as productivity or turnover or patient safety rates for the entire team. This suggests that burnout assessments should also be aggregated measures. This is especially relevant for any decisions about implementing interventions across work teams or entire departments. Outside of healthcare, there is evidence that burnout is more meaningful if measured at the team level.^{32 33} This is because burnout is a social phenomenon rooted in the relationships that people share in work teams.



BMJ 2019;366:l4774 doi: 10.1136/bmj.l4774 (Published 30 July 2019)

Workload—Overload is a feature of frontline care that means there is little opportunity to rest, recover, and restore balance. Managing workload and recognising boundaries can provide opportunities that can help staff feel effective in their work

Control—Experiencing a lack of control has been a consistent predictor of burnout. Conversely, the perception of having the capacity to influence decisions and exercise professional autonomy is more likely to lead to resilient and engaged physicians

Reward—Insufficient recognition and reward (whether financial, institutional, or social) increases people's vulnerability to burnout because it devalues both the work and the workers, and it is closely associated with feelings of inefficacy. Feeling that you are appropriately and consistently rewarded is associated with intrinsic satisfaction, which is the optimum state for healthcare staff. This is an area where patients can contribute

Community—Regardless of their size, healthcare organisations are social communities. The area of community has to do with the ongoing relationships that people have with others on the job. Whether it is a rural general practice or a large university hospital, relationships that are characterised by a lack of support and trust, and by unresolved conflict, all mean a greater risk of burnout

Fairness—Fairness is the extent to which decisions at work are perceived as being fair and equitable. This factor is the one most directly relevant to patient care. Patients and health staff will experience feelings of cynicism, anger, and hostility if they don't feel they are being treated appropriately

Values—Values are the ideals and motivations that originally attracted people to their job, and thus they are the motivating connection between the worker and the workplace. Feeling that the work that you have to do is far away from what you want to do can lead to greater burnout.

Caring for doctors Caring for patients

**How to transform UK healthcare
environments to support doctors and
medical students to care for patients**

Professor Michael West and Dame Denise Coia

A: Autonomy and control

Voice, influence and fairness

To introduce mechanisms for doctors in primary and secondary care to influence the culture of their healthcare organisations, and decisions about how medicine is delivered.

How: Clinical leaders and managers should consult doctors (and other healthcare staff) and gather feedback about how healthcare teams are established and maintained, how their work is organised and delivered and the response to concerns to ensure a focus on learning not blame.

Work conditions

To introduce UK-wide minimum standards for basic facilities in healthcare organisations.

How: All healthcare employers should provide all doctors with places and time to rest and sleep, access to nutritious food and drink, the tools needed to do their job and should implement the BMA's Fatigue and Facilities charter.

Work schedule and rotas

To introduce UK-wide standards for the development and maintenance of work schedules and rotas based on realistic forecasting that supports safe shift swapping, enables breaks, takes account of fatigue and involves doctors with knowledge of the specialty to consider the demands that will be placed on them.

How: NHS England, NHS Wales, NHS Boards in Scotland and the Department of Health (Northern Ireland) should fully implement the BMA's and NHS Employers' Good Rostering Guide ([see new deal monitoring guidance](#) in Scotland) in all healthcare environments.

B: Belonging

Team working

To develop and support effective multidisciplinary team working across the healthcare service.

How: All healthcare organisations should review team working and ensure that all doctors are working in effectively functioning and, ideally, multidisciplinary teams. The teams should have a shared purpose and clear objectives (one of which is team member wellbeing). Team members should be clear about their roles and meet regularly to review their performance, including inter-team/cross-boundary working. Quality improvement should be a core function of all teams.

Culture and leadership

To implement a programme to ensure healthcare environments have nurturing cultures enabling high-quality, continually improving and compassionate patient care and staff wellbeing.

How: All UK healthcare organisations that haven't already done so, should start and implement a programme of compassionate leadership across all healthcare sectors; and they should obtain feedback from doctors and healthcare staff to evaluate its effectiveness. It should include mechanisms to ensure clinical leads and other leaders of doctors at all levels in the healthcare system are recruited, selected, developed, assessed and supported to model compassionate and collective leadership.

C: Competence

Workload

To tackle the fundamental problems of excessive work demands in medicine that exceed the capacity of doctors to deliver high-quality safe care.

How: All organisations that oversee the work of doctors should undertake, in collaboration with doctors, a programme to review workload in their organisations. This will help them to use resources in the most efficient way, to ensure workloads do not exceed doctors' ability and capacity to deliver safe, high-quality care. Initiatives are underway across the UK to increase staffing numbers and this should be supported by additional solutions including, but not restricted, to:

- A programme to deploy and develop alternative roles to enable doctors to work at the top of their competence, supported by effective multidisciplinary team working in all areas of healthcare, and to support doctors to return to work after a break in practice.
- A review of new technologies being used in UK healthcare systems to increase efficiency, working with the voluntary sector, and focusing on preventive care.
- A programme of process improvements that increase productivity especially by supporting communication in regular team meetings between healthcare staff.

END OF LECTURE – FURTHER MATERIAL NOT USED IN LECTURE BELOW

Strategies to Reduce Burnout



Acknowledge and assess the problem



Harness the power of leadership



Develop and implement targeted work unit interventions^a



Cultivate community at work



Use rewards and incentives wisely



Align values and strengthen culture



Promote flexibility and work-life integration



Provide resources to promote resilience and self-care



Facilitate and fund organizational science

Empathy and burnout: a study on residents from a Singapore institution

Phong Teck Lee¹, MBChB, *Julian Loh¹*, MB BCh BAO, *Gerald Sng²*, MBBS, *Joshua Tung²*, MBBS, *Khung Keong Yeo^{1,3}*, MBBS

INTRODUCTION Empathy and burnout are two entities that are important in a physician's career. They are likely to relate to each other and can be heavily influenced by surrounding factors, such as medical education, local practices and cultural expectations. To our knowledge, empathy and burnout studies have not been performed in Singapore. This study was designed to evaluate empathy and burnout levels using the Jefferson Scale of Physician Empathy (JSPE) and Maslach Burnout Inventory (MBI) among residents in Singapore, and compare them with the United States (US) literature.

METHODS The JSPE, MBI and a self-designed questionnaire were completed by 446 trainees at a residency-sponsoring institution in Singapore.

RESULTS Residents in Singapore had lower empathy and higher rates of burnout compared to US literature. Physician empathy was associated with burnout: residents with higher empathy scores had higher personal accomplishment ($p < 0.001$, $r = 0.477$, $r^2 = 0.200$); and lower emotional exhaustion ($p < 0.001$, $r = 0.187$, $r^2 = 0.035$) and depersonalisation ($p < 0.001$, $r = 0.321$, $r^2 = 0.103$) scores.

CONCLUSION Residents in Singapore had lower empathy and higher burnout scores compared to the US literature. Further research into the underlying cause is imperative to guide intervention.

360 out of 446 (80.7%) residents had burnout in at least one of the domains

To our knowledge, this was the first study in Singapore to evaluate empathy and burnout among residents. Our findings suggest that empathy is lower and burnout higher among our residents when compared to US residents.^(1,11-13,29) This is likely a reflection of multiple factors, ranging from medical education to work factors, such as hospital work-hours and policies, as well as societal expectations on physicians. Nevertheless, this issue is alarming, as empathy decline and high burnout can have serious repercussions for physicians' well-being and adversely affect quality of patient care.⁽⁹⁾

Emotional exhaustion and workload predict clinician-rated and objective patient safety



Annalena Welp^{1*},



Laurenz L. Meier² and



Tanja Manser³



Study

Published March 2015

Impact of organizational leadership on physician burnout and satisfaction.

Shanafelt TD, Gorringer G, Menaker R, et al. Mayo Clin Proc. 2015;90:432-440.

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Burnout has reached [epidemic proportions](#) among physicians in the United States. In this survey of physicians working within a large health care organization, burnout was inversely



'All doctors have a responsibility to take action if they are aware that patient safety may be put at risk,' says the

The **General Medical Council** has asked the NHS to share concerns about any doctors involved in poor care at the Shrewsbury and Telford Hospital Trust.

It comes as West Mercia Police said it was considering a range of criminal charges against the hospital including corporate manslaughter.

The medical watchdog said it was in touch with the Shropshire trust, where **dozens of babies and three mothers may have died as a result of widespread poor care** and a "toxic culture" stretching back over four decades.

Anthony Omo, director of fitness to practice for the GMC, said the reports of poor maternity care at the trust were "shocking" and his thoughts were with the families.

He added: "We are in contact with the trust and have asked NHS England and NHS Improvement for details of any concerns about individual doctors.

Doctors may face suspension over NHS 'worst maternity scandal'

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There is abundant evidence that workplace stress in healthcare organisations affects quality of care for patients as well as doctors' own health.

The wellbeing of doctors is vital because it is linked to a significant problem with retaining doctors.

Our aim should be to ensure that the NHS is a model for the world, in creating workplaces that support doctors and other healthcare staff by promoting their mental health and wellbeing.

The trust joins the roll call of [NHS](#) hospitals where endemic poor care has caused harm and death. Failings uncovered at Shrewsbury include a lack of transparency and honesty, defensiveness, a disrespectful and unkind attitude to families, a failure to learn from or even recognise serious incidents, and a “toxic” culture.

The [2015 inquiry](#) (pdf) into deaths of babies and mothers at University hospitals of Morecambe Bay NHS foundation trust, the [Francis inquiry](#) two years earlier into failures at Mid Staffordshire, and the 2001 landmark [public inquiry](#) (pdf) into children’s heart surgery at Bristol Royal infirmary all revealed layer upon layer of systemic failings. These included the breakdown of teamwork, poor leadership, lack of respect between professional groups, a tolerance of poor standards, defensiveness, dishonesty, failure to assess risks, and repeated failures to recognise and investigate serious incidents.

Boards, senior NHS management and regulators either missed the problems or did not take decisive action.

ON THE BRINK Burnout is classified as a **DISEASE** by the World Health Organisation – the 8 signs you're at risk

By [Gemma Mullin](#), Digital Health Reporter

28th May 2019, 10:41 am | Updated: 28th May 2019, 4:18 pm

400

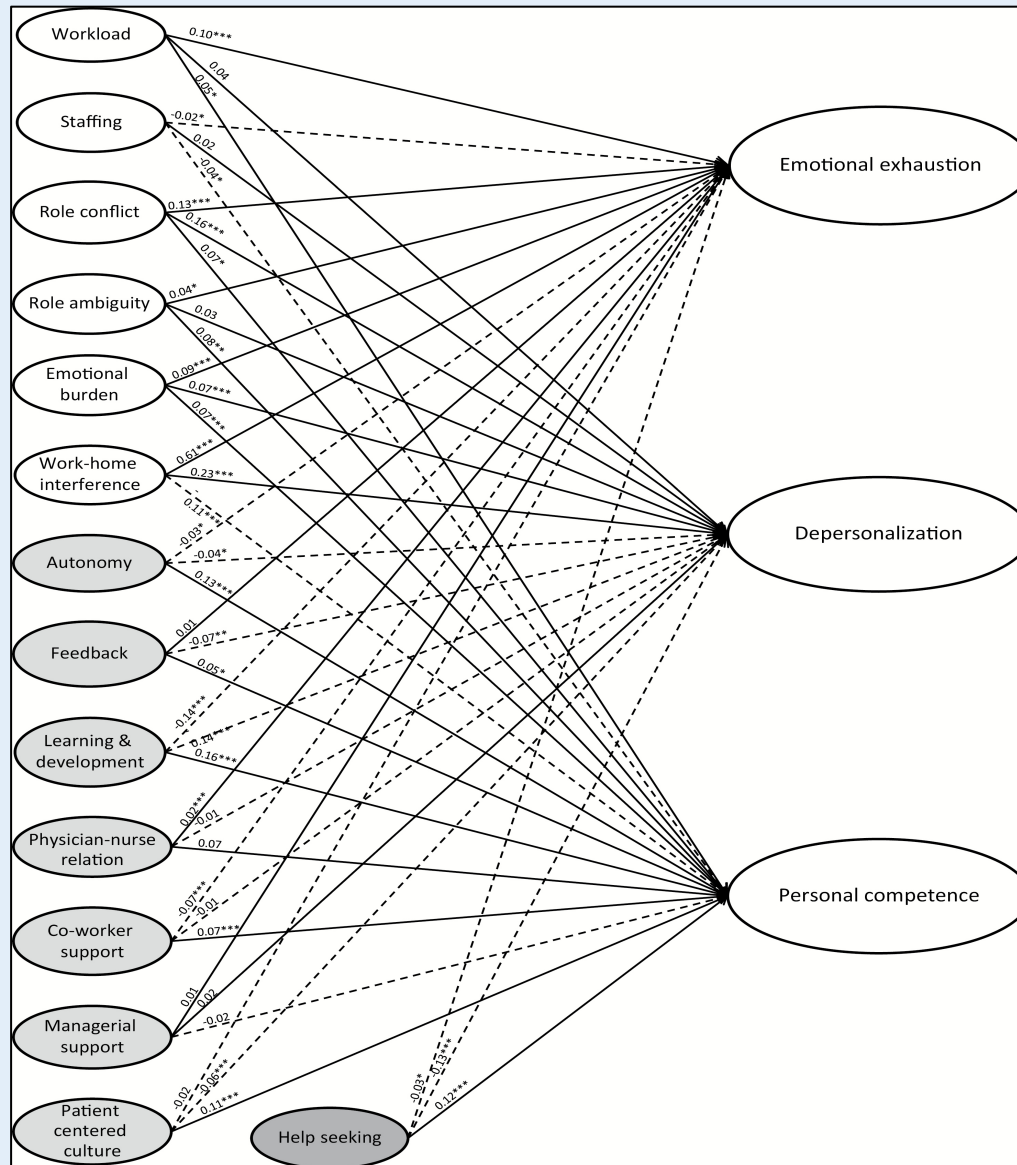
U.S. physicians take
their own lives
every year.

Let's talk about it.

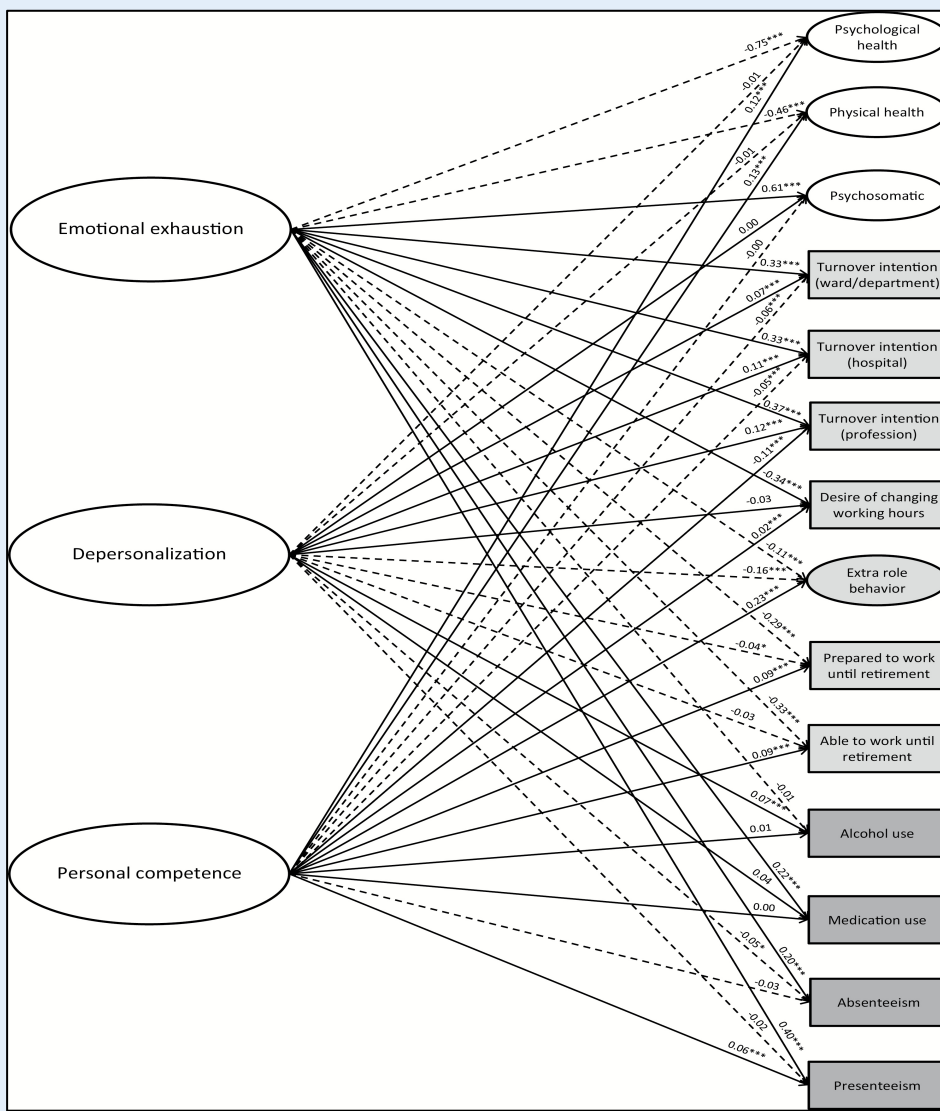
Breaking the Culture of Silence on Physician Suicide

An NAM Perspective

SEM model including job-demands and resources linked to the burnout dimensions (Aim 3). The numbers represent ...



SEM model including burnout dimensions linked to outcomes of well-being, work-related attitudes and ...



Compassionate leadership

Attending	Understanding	Empathising	Helping
Effective leadership <ul style="list-style-type: none"> • <i>Direction</i> A clear, shared, inspiring purpose or vision • <i>Alignment</i> Clear goals for people and teams 	Inclusive leadership <ul style="list-style-type: none"> • Clear, shared, inspiring purpose or vision • Positively valuing difference • Frequent face to face 	Collective leadership <ul style="list-style-type: none"> • Everyone has leadership responsibility • Shared leadership in teams • Interdependent leadership 	System leadership <ul style="list-style-type: none"> • Shared vision and values • Long term objectives • Frequent face to face contact

Helping includes:

- focusing on what is most useful for the other
- taking action that addresses suffering
- creating flexible time to cope with suffering, buffering others from overload
- avoiding legalistic approaches that deny human connection
- addressing corrosive politics, toxic interactions, underperformance via ‘fierce compassion’
- empathising, integrity and confidentiality
- recognising that compassion is neither weak nor vulnerable

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- empathising, integrity and confidentiality
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Compassionate leadership comprises four elements:

Attending: The first element of compassionate leadership is being present with and attending to those we lead. Leaders who attend will model being present with those they lead and 'listening with fascination' (Kline, 2002).

Understanding: The second component involves leaders appraising the situation those they lead are struggling with to arrive at a measured understanding. Ideally, leaders arrive at their understanding through dialogue with those they lead and perhaps have to reconcile conflicting perspectives rather than imposing their own understanding.

Empathising: The third component of compassionate leadership is empathising. Compassionate leadership requires being able to feel the distress or frustration of those we lead without being overwhelmed by the emotion and therefore unable to help.

Helping: The fourth and final component is taking thoughtful and intelligent action to help the other. Probably the most important task of leaders in healthcare is to help those they lead to deliver the high-quality, compassionate care they want to provide.

What compassionate leadership does not mean is:

- loss of commitment to purpose, high-quality performance or good performance management
- difficult conversations being labelled as bullying
- always taking the easy, consensus way forward rather than putting patients and communities first
- not being able to challenge the status quo and make the radical changes patients and communities need or
- team work and system working being controlled by whoever has the most power and is most ruthless (see <https://www.kingsfund.org.uk/blog/2019/05/five-myths-compassionate-leadership>).

- Rarely see consultant colleagues – no peer support
- No social interaction
- Old “firm structure” gone
- Junior staff change constantly – no relationships just demands for supervision
- Management changes frequently
- Consultants working as registrars in higher risk specialties
- Higher patient throughput
- More regulatory demands
- Burnout is inevitable